

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05281

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County.....

Worchester

City or town..... Berlin, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 year

Hospital, institution, or street address where death occurred:..... no

How long in hospital or institution?..... no

## 3. (a) FULL NAME

Samuel Waters Bauer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male a a married

6. (b) Name of husband or wife

Martha E. Bauer

7. Birth date of deceased (mo., day, yr.)

Nov 15 1869

6. (c) If alive, give age

years

8. AGE:

Years      Months      Days      less than one day

76

5

5

hrs. min.

9. Birthplace.....

Worchester Co.

(Town, county, and state)

10. Usual occupation.....

Tobacconist

11. Industry or business.....

Same as above

MOTHER FATHER

12. Name..... Harry Snark

13. Birthplace.....

Berlin, Md

MOTHER

14. Maiden name..... Mary Scouled

15. Birthplace.....

Berlin, Md

16. Informant.....

Mrs. Martha Bauer

Address.....

Berlin, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Nov 9 1946

(month day year)

Cemetery or crematory..... Evergreen

Location.....

Berlin, Md

18. Funeral director.....

James P. Stewart

Address.....

Salisbury, Md

19. 5-7-

(Date rec'd by registrar)

1946

Helen F. Maynard

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Worchester

City or town.....

County.....

Berlin, Md

Street No.....

County.....

S. Lower St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-5-46 1946 5P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15 46 to 5-3-46 46

and that I last saw him alive on 5-3-46 1946

Immediate cause of death.....

Hypertension

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Clifford E. Odelet

M. D. or other

Address.....

Baltimore, Md

Date signed..... 5/7/46





MARGIN RESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

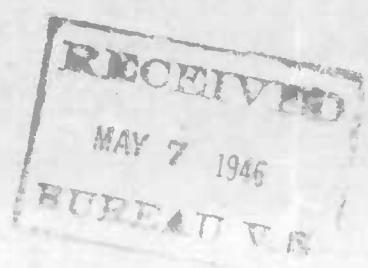
2411 N. Charles St., Baltimore 8-30

05282

## **CERTIFICATE OF DEATH**

Reg. Dist. No. .... 355.

1. PLACE OF DEATH:		Westerster Olean City, N.Y.		
County.....		Westerster		
City or town.....		(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?		as of year		
Hospital, Institution, or street address where death occurred:		no		
How long in hospital or institution?		no		
3. (a) FULL NAME		Doris Gaster		
4. Sex		5. Color or race		6.(a) Single, married, widowed, or divorced
male		a-a - Married		
B.(b) Name of husband or wife		Lameta Gaster		
7. Birth date of deceased (mo., day, yr.)		March 26, 1876		
8. AGE: Years		Months	Days	If less than one day
69		4	29	hrs. min.
9. Birthplace		Columbus, S.C.		
		(Town, county, and state)		
10. Usual occupation		Laundry		
11. Industry or business		Same as above		
FATHER	12. Name		Aspinwall	
MOTHER	13. Birthplace		Unknown	
	14. Maiden name		Aspinwall	
	15. Birthplace		Unknown	
16. Informant		Lameta Gaster		
Address		Olean City, N.Y.		
17. Burial		Date thereof	May 5, 1946	
(Burial, cremation, or removal). Which?		(month)	(day)	(year)
Cemetery or crematory		Local Cemetery		
Location		Near Smallfield		
18. Funeral director		James H. Alward		
Address		Baltimore, Md.		
19. 5-4		1946	Helen F. Hayward	
(Date rec'd by registrar)		Registrar	M. D. <i>yes/no</i>	
20. DATE OF DEATH		May 1, 1946		
21. STATEMENT that death occurred on the date above stated; that I attended deceased from		March 1, 1946, to April 26, 1946,		
and that I last saw her alive on		April 26, 1946.		
Immediate cause of death		Cerebral edema		
Due to		Hypertension		
Due to		Aortitis		
Other conditions				
(Include pregnancy within 3 months of death)				
Major findings of operations		Date of op.		
Autopsy results				
PHYSICIAN: Please underline the cause to which death should be charged statistically.				
22. VIOLENCE: If death was due to external causes, fill in the following:				
Accident, suicide, or homicide		Date of		
Where did injury occur?		(City or town)	(County)	(State)
Injured at home, farm, industry, public place (where?)				
Meane of injury		Injured at work?		
23. SIGNATURE		<i>Charles E. Johnson</i>		
Address		Oskar W. <i>5-3-4</i>		
M. D. <i>yes/no</i>		Date signed		



**Reg. Dist. No.**

## **CERTIFICATE OF DEATH**

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

**1. PLACE OF DEATH:** *Worley*  
 County.....  
 City or town. *Snow Hill*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *0 mo*  
 Hospital, Institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_  
**3. (a) FULL NAME** *Emma J. Lehiser*

4. Sex <i>Female</i>	5. Color or race <i>White</i>	6.(a) Single, married, widowed, or divorced <i>Widowed</i>
----------------------	-------------------------------	--

6.(b) Name of husband or wife *Albert Lehiser*

7. Birth date of deceased (mo., day, yr.) *701. 11 / 1861*

8. AGE: Years *84* Months *6* Days *1* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Emporiaville, Accomac, Virginia*  
 (Town, county, and state) *None*

10. Usual occupation.....

11. Industry or business *Thomas Taylor*

**MOTHER FATHER**

12. Name *Thomas Taylor*

13. Birthplace *Virginia*

14. Maiden name *Albert Lehiser*

15. Birthplace *Virginia*

16. Informant *Miss Martha Jackson*

Address *Snow Hill, MD*

17. Burial, cremation, or removal, Which? *Burial* Date thereof *May 14/46*  
 (month) (day) (year)

Cemetery or crematory *Baptist*

Location *Snow Hill, MD*

18. Funeral director *George + Dennis*

Address *Snow Hill, MD*

19. Date rec'd by registrar *5/14/46* *Elroy Smith*  
 (Date rec'd by registrar)   
 Registrar

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)

State..... *Maryland*, County..... *Baltimore*

City or town..... *Baltimore* Hill  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION) *70*

2.(a) If veteran, name war.....

3. (b) Social Security Number *None*

### MEDICAL CERTIFICATION

20. DATE OF DEATH *May 12* 19 *44*, at *702*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *December 1945* 19....., to *May 12, 1946* 19....., and that I last saw her *alive on May 12, 1946* 19.....

Immediate cause of death..... *myocarditis, chronic*

Due to.....

Due to.....

Other conditions..... *Gastric cystitis*  
*Gastritis*

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

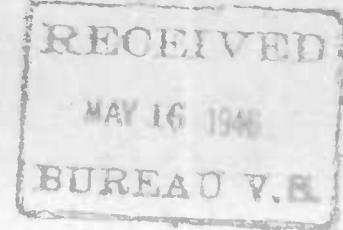
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE *Frank D. Lewis M.D.* M. D. or other *Millard Maryland* Date signed *May 13/44*

Address.....



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(B-2)

05284

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County..... Worcester

City or town..... Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 40 years

Hospital, institution, or street address where death occurred: —

How long in hospital or Institution?..... —

## 3. (a) FULL NAME

Clara Blanche Coston

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Married

6. (b) Name of husband or wife.

Marvin Coston

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.)

July 17 1868

8. AGE: Years 77 Months 9 Days 20 If less than one day hrs. min.

9. Birthplace: Ocean City, Md. (town, county, and state)

10. Usual occupation:

Housewife

11. Industry or business

12. Name: Harry Gray Powell

13. Birthplace: Md.

14. Maiden name: Clara Blanche Bowen

15. Birthplace: Md.

16. Informant: Mrs. Herbert Gladding

Address: Pocomoke City Md.

17. Burial: Cemetery: May 9, 1946  
(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Salem M. C. Cemetery

Location: Pocomoke City Md.

18. Funeral director: Harry Gladding

Address: Pocomoke Md.

19. Date rec'd by registrar: May 8, 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No: 7 Second Street

(If rural, give LOCATION)

2. (a) If veteran, name war: —

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1946, to May 7, 1946, and that I last saw her alive on May 6, 1946.

Immediate cause of death:

Coronary Thrombosis. DURATION: 1 Hour.

Due to: Cardio-Vascular Renal Dis. SEVERAL HRS.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

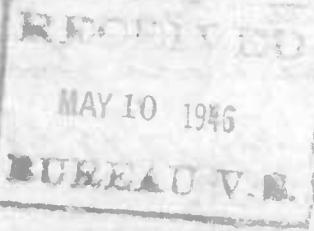
Means of injury

Injured at work?

23. SIGNATURE: Louis S. Cleveland, MD

M.D. or other

Address: Pocomoke City, Md. Date signed: 5-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

05285

Reg. Dist. No.

350

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Worcester  
 County: Pocomoke City  
 City or town: (If outside city or town limits, write RURAL and give nearest town) Lifetime

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: 509 Bonneville Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Maryland County: Worcester  
 City or town: Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town) 509 Bonneville Ave  
 Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

FANNY CROPPER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 20, 1913

8. AGE: Years Months Days If less than one day  
 33 3 20 hrs. min.

9. Birthplace Pocomoke City-Worcester-Md.  
 (Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business Poultry dressing plant

MOTHER FATHER  
 12. Name John Ross

13. Birthplace Worcester Co. Md.

MOTHER  
 14. Maiden name Eunice Schoolfield

15. Birthplace Pocomoke City, Md.

16. Informant Lelia Cropper

Address 509 Bonneville, Pocomoke, Md.

Burial Date thereof May 7, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hall's Hill Cemetery

Location Pocomoke City, Md.

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

May 8, 1946 Anne E. White

(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1946 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Pocomoke City, Md., 10 days before death.

and that I last saw her alive on May 4, 1946.

Immediate cause of death Pneumonia, B.

DURATION 2 weeks

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

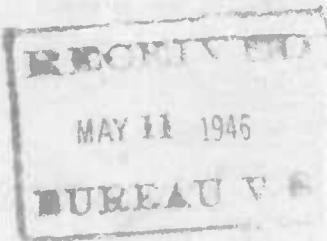
Means of injury Injured at work?

23. SIGNATURE Date signed 5-7-46

M. D. or other

Address

Date signed 5-7-46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

05286

355

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Worcester  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....3 yrs  
 Hospital, Institution, or street address where death occurred:  
Shawells Route 1  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State.....Md. County.....War.  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

3. (a) FULL NAME  
Gertrude Phoby Ellen Powell Donoway

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife	<u>George Washington Donoway</u>		
-------------------------------	----------------------------------	--	--

7. Birth date of deceased (mo., day, yr.)	<u>July 13 1922</u>		
---	---------------------	--	--

8. AGE:	Years	Months	Days	If less than one day
	23	9	24	hrs. min.

9. Birthplace	<u>Libertytown</u>		
---------------	--------------------	--	--

10. Usual occupation	<u>House Wife</u>		
----------------------	-------------------	--	--

11. Industry or business	<u>None</u>		
--------------------------	-------------	--	--

12. Name	<u>George Powell</u>		
----------	----------------------	--	--

13. Birthplace	<u>Timmonsboro</u>		
----------------	--------------------	--	--

14. Maiden name	<u>Eva Mae Griffin</u>		
-----------------	------------------------	--	--

15. Birthplace	<u>Powellsville Md</u>		
----------------	------------------------	--	--

16. Informant	<u>George W. Donoway</u>		
---------------	--------------------------	--	--

Address	<u>Berlin Md Route 1</u>		
---------	--------------------------	--	--

17. Burial	Date thereof	<u>May 9th 1946</u>	
------------	--------------	---------------------	--

(Burial, cremation, or removal, Which?)	(month)	(day)	(year)
---	---------	-------	--------

Cemetery or crematory	<u>Riverside</u>		
-----------------------	------------------	--	--

Location	<u>Libertytown</u>		
----------	--------------------	--	--

18. Funeral director	<u>Wm. Howard Wells</u>		
----------------------	-------------------------	--	--

Address	<u>Pillsboro Md.</u>		
---------	----------------------	--	--

19. Date rec'd by registrar	19. H.G.	Helen F. Hayward	Registrar
-----------------------------	----------	------------------	-----------

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1946 at 5-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946 to May 6 1946 and that I last saw her alive on May 6 1946.

Immediate cause of death

Tuberculosis -  
Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

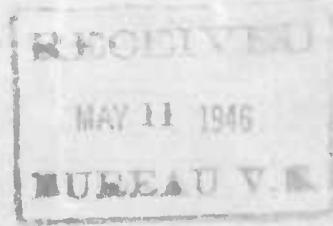
Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Oleffor E. Dehart  
Address.....  
Date signed..... May 8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

05287

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester  
 County: Showells M.d.  
 City or town: Showells M.d.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, Institution, or street address where death occurred  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Maryland County: Worcester  
 City or town: Showell, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

3. (a) FULL NAME Sallie Marie Donovan

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	Single

3. (b) Social Security Number

6. (b) Name of husband or wife.....  
 B. (c) If alive, give age ..... years

7. Birth date of deceased (mo. day. yr.) January 30 - 1946

8. AGE: Years 3 Months 26 Days 0 If less than one day hrs. min.

9. Birthplace Showells M.d. (Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER 12. Name Ged W Donovan

13. Birthplace W Laurel Delaware

14. Maiden name Gertrude Powell

15. Birthplace Berlin Md

16. Informant Ged W Donovan

Address Showells M.d.

17. Burial Date thereof May 27-1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bear Liberty Lwn M.d.

Location Riverside Cemetery

18. Funeral director Wm. Bernard Wells

Address Pittsville, Md.

19. 5-27- 1946 Helen F. Hayward  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1946, at 5 a.m.

21. I CERTIFY that death occurred on the date above-stated; that I attended deceased from May 15 1946, to May 26 1946, and that I last saw her alive on May 15 1946.

Immediate cause of death  
Tuberculosis  
Tuberculosis

Due to.....

Due to.....

Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

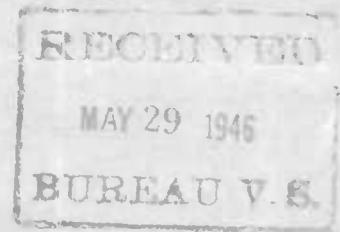
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other

Address Baltimore, Md. Date signed 5/27/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05288

## CERTIFICATE OF DEATH

Reg. Dist. No. 3 S.S.

## 1. PLACE OF DEATH:

County.....

City or town.....

Worcester  
Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

70 years.

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

David James Downey.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married.

6. (b) Name of husband or wife.....

Jennie Downey

7. Birth date of deceased (mo., day, yr.)

Aug. 7, 1874

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Maryland

10. Usual occupation.....

Farmer.

11. Industry or business

FATHER

12. Name..... John Downey

13. Birthplace..... Md.

MOTHER

14. Maiden name..... Annie Hastings

15. Birthplace..... Md.

16. Informant.....

Mrs. David J. Downey

Address.....

Berlin Md.

17. Burial.....

Burial Date thereof..... 5/31/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Evergreen Cemetery

Location.....

Berlin Md.

18. Funeral director.....

Anne A. Burbage

Address.....

Berlin Md.

19. 5-31-

(Date rec'd by registrar)

1946 Helen F. Hayward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County..... Worcester

City or town.....

Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

5-29

46 46 46

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

1-1-46 19 to 5-28-46 19

and that I last saw h... alive on 5-28-46 19

Immediate cause of death..... Chronic Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE

Oxford E. Schett

M. D. together

Address.....

Berlin Md.

Date signed..... 5-30-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Signature)*

05289

## CERTIFICATE OF DEATH

Reg. Dist. No. *357*

## 1. PLACE OF DEATH:

County *Worcester*City or town *Snow Hill*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Aintha J. Ellis*4. Sex *F*5. Color or race *white*6.(a) Single, married, widowed, or divorced *widow*6.(b) Name of husband or wife *John J. Ellis*7. Birth date of deceased (mo., day, yr.) *Nov 21 1866*6.(c) If alive, give age *years*

8. AGE:

Years *79*Months *5*Days *28*

If less than one day

hrs. *.*min. *.*9. Birthplace *Snow Hill Md*

(Town, county, and state)

10. Usual occupation *Housewife's*

## 11. Industry or business

MOTHER

FATHER

12. Name *Benjamin Davis*13. Birthplace *Maryland*14. Maiden name *Jane Larr.*15. Birthplace *Maryland*16. Interment *Snow Hill*Address *Snow Hill Md*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *May 21/46*

(month) (day) (year)

Cemetery or crematory *Whitfoot*Location *Snow Hill Md*18. Funeral director *Steam & Dennis*Address *Snow Hill Md*19. Date rec'd by registrar *5/20/46*19. *46**L. Roy Smith*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Worcester*City or town *Snow Hill*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *70*

(If rural, give LOCATION)

2.(a) If veteran, name war *70*3. (b) Social Security Number *301*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 19*19 *46* at *1:30 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

19...

and that I last saw h. alive on

19...

Immediate cause of death

*Myocardial degeneration  
of heart*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

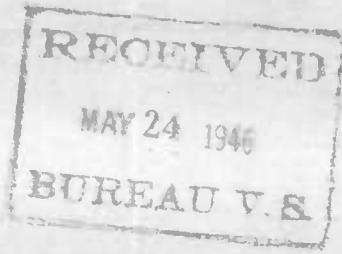
Means of Injury

Injured at work?

23. SIGNATURE *John F. Riley M.D. New Haven*

M. D. or other

Address *Snow Hill Md*Date signed *5/19/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

05290

351

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

George E. Grant

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

widowed

6.(b) Name of husband or wife.....

Mary A. Grant

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age.....years

8. AGE:

Years      Months

Days

If less than one day

91      0      19      hrs.      min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

William T. Grant

MOTHER FATHER

12. Name.....

William T. Grant

13. Birthplace

Pennsylvania

14. Maiden name.....

Rachel A. Rothheimer

15. Birthplace

Pennsylvania

16. Informant.....

Robert T. Grant

Address

Snow Hill, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day), (year)

Cemetery or crematory

Tomfred Chapel

Location

Snow Hill, Md.

18. Funeral director.....

Harkie &amp; Sonnies

Address

Snow Hill, Md.

19. Date rec'd by registrar

19. 5/9/46

Lex Day Sevick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Wicomico

City or town.....

Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

70

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8 1946 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....to.....19.....

and that I last saw h.....alive on.....

Immediate cause of death.....

Decompensated hypertension  
arteriosclerotic cardio-

Due to.....renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

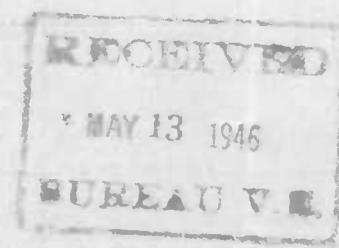
Paul Cohen M.D.

M. D. or other

Address.....

Snow Hill

Date signed.....5/9/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05291

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

King Solomon Jenkins

4. Sex

M C

5. Color or race

Single

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Feb 12 1896

8. AGE:

Years Months Days If less than one day

50 3

hrs. min.

9. Birthplace

(Town, county, and state)

D.C.

10. Usual occupation

11. Industry or business

Solomon Jenkins

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

May 9 1946

Anne White

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

City or town

Seaford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

My son died of pneumonia

DURATION

Due to

Brain hemorrhage

5

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

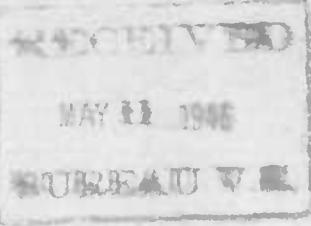
Means of injury ..... Injured at work?

23. SIGNATURE

C. G. Jenkins M. D. or other

Date signed 5-2-46

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05292

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County ..... Worcester

City or town ..... Shawell

(If outside city or town limits, write RURAL and give nearest town)

43 yrs.

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

John M. Moore

4. Sex ..... Male 5. Color or race ..... White 6. (a) Single, married, widowed, or divorced ..... Married

Lillian Alice Moore

6. (b) Name of husband or wife:.....

6. (c) If alive, give age ..... 81 years

7. Birth date of deceased (mo. day. yr.) ..... Oct 29, 1856

8. AGE: Years ..... 89 Months ..... 6 Days ..... 25 If less than one day ..... hrs. ..... min.

9. Birthplace ..... Roxana Delaware (Town, county, and state)

10. Usual occupation ..... Retired

11. Industry or business ..... "

12. Name ..... Mayette B. Moore

13. Birthplace ..... Del.

14. Maiden name ..... Lucy Bunting

15. Birthplace ..... Del.

16. Informant ..... Mrs. Lillian A. Moore

Address ..... Shawell, Md.

17. Burial ..... Burial Date thereof ..... May 26, 1946

(Burial, cremation, or removal. Which?) Cemetery or crematory ..... O.O.F.

Location ..... Bushpawville, Md.

18. Funeral director ..... Mr. Rusha Watson

Address ..... Selbyville, Del.

19. S-25 Date rec'd by registrar ..... 1946

(Date rec'd by registrar) Helen F. Hayward Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... Worcester

City or town ..... Shawell (If outside city or town limits, write RURAL and give nearest town)

Street No ..... no street (If rural, give LOCATION)

2. (a) If veteran, name war:.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... May 24 1946 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1946 to May 24, 1946 and that I last saw him alive on May 23, 1946

Immediate cause of death: Chronic Myocarditis

Due to Arteriosclerotic Heart Disease

Due to Generalized Arteriosclerosis

DURATION 10 days

20 days

40 days

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Date of

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

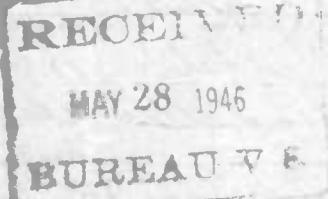
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Spec's W.D. M. D. or other

Address ..... Belie Mel Date signed ..... May 26, 1946



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

## CERTIFICATE OF DEATH

105293350  
Reg. Dist. No.

1. PLACE OF DEATH: Worcester  
 County.....  
 City or town..... Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 20 years  
 How long in above place of death?  
 Hospital, Institution, or street address where death occurred:  
 Home, 4th Street  
 How long in hospital or institution?

3. (a) FULL NAME  
 Bertie Lee Northam

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

Charles G. Northam

8.(b) Name of husband or wife.....  
 8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 20, 1880

8. AGE:	Years	Months	Days	If less than one day
	65	6	24	.....hrs. .....min.

Girdletree-Worcester-Maryland

9. Birthplace.....  
 (Town, county, and state)  
 Housewife

10. Usual occupation.....  
 Home

11. Industry or business.....  
 Syrinus Robertson

MOTHER FATHER  
 12. Name..... Syrinus Robertson  
 13. Birthplace..... Worcester Co., Maryland

14. Maiden name..... Amanda Robertson  
 15. Birthplace..... Worcester Co., Maryland

16. Informant.....  
 Charles G. Northam

Address.....  
 4th St., Pocomoke City, Md.

17. Burial..... Date thereof..... May 16, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....  
 Downing Cemetery  
 Location.....  
 Oak Hall, Virginia

18. Funeral director.....  
 H. Harvey Bradshaw  
 Address.....  
 Pocomoke City, Maryland

19. Date rec'd by registrar..... May 16, 1946  
 (Date rec'd by registrar)..... Anne E. White  
 Registrar.....  
 Address.....  
 Date signed..... 5-16-46

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Maryland	County..... Worcester
City or town..... Pocomoke City	(If outside city or town limits, write RURAL and give nearest town)
Street No..... 4th Street	(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 16, 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to May 14, 1946, and that I last saw her alive on May 1, 1946.

Immediate cause of death..... Myocardial degeneration 4 years

Due to..... Arteriosclerosis 82

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... C. S. C. E. T. M. D. or other

Date signed..... 5-16-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

05294

1. PLACE OF DEATH: Worcester  
 County Snow Hill  
 City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 years  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City of town Snow Hill (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) Is veteran, name war? Y.D.

3. (a) FULL NAME Mary Alice Puttman

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife John H. Puttman  
 7. Birth date of deceased (mo., day, yr.) May 14 - 1895 8. (c) If alive, give age 54 years

8. AGE: Years 51 Months 0 Days 7 It less than one day hrs. 0 min.

9. Birthplace Glaston, Mathews Virginia (Town, county, and state)

10. Usual occupation Crocheter

11. Industry or business Textile Factory

MOTHER FATHER  
 12. Name Hazel Diggs

13. Birthplace Virginia

14. Maiden name Mabel Beale

15. Birthplace Virginia

16. Informant Mrs John H. Puttman

Address Snow Hill, Md

Burial Date thereof May 24/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christian

Location Snow Hill, Md

18. Funeral director Hearne + Dawson

Address Snow Hill, Md

19. Date rec'd by registrar 5/23/46 19. Date signed 5/22/46  
 (Date rec'd by registrar) (Date signed)

Registrar

3. (b) Social Security Number \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19. 46, at 2:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 19. 46, to May 22 19. 46 and that I last saw her alive on May 21 19. 46.

Immediate cause of death Cancer of uterine cervix

DURATION 1 year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

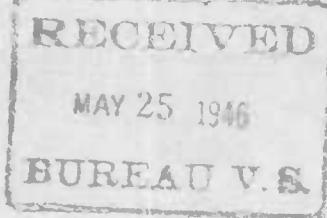
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James B. Smith M.D. M. D. or other \_\_\_\_\_

Address Snow Hill Date signed 5/22/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 05295 355

## 1. PLACE OF DEATH:

County MarylandCity or town Berlin (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: noHow long in hospital or institution? no

## 3. (a) FULL NAME

Charles Robbins4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife no 6. (c) If alive, give age no years7. Birth date of deceased (mo. day, yr.) about 6. (c) If alive, give age 1870 years8. AGE: Years about 76 Months — Days — If less than one day hrs. — min.9. Birthplace Berlin (Town, county, and state) MD10. Usual occupation Laborer11. Industry or business Same as above12. Name William Pitts13. Birthplace Berlin14. Maiden name Grace Gillis15. Birthplace Berlin (MD)16. Informant Blara BraddellAddress Berlin - MD17. Burial Date thereof May 26 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Germann TownLocation Berlin (MD)18. Funeral director James F. StewartAddress Baltimore (MD)19. 5-26 19 4-6 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MarylandCity or town Berlin (If outside city or town limits, write RURAL and give nearest town)Street No. no (If rural, give LOCATION)2.(a) If veteran, name war no3. (b) Social Security Number no

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 5-23 46 6-921. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-20 46 to 5-23 46 and that I last saw him alive on 5-21 46Immediate cause of death Chronic Myocarditis DURATION 7Due to My pertensionDue to SensitivityOther conditions 

(Include pregnancy within 8 months of death)

Major findings of operations  Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Clifford E. Schott M. D. or other Address 30 Main Berlin MD Date signed 5/24/46

RECEIVED  
MAY 28 1946  
BUREAU V R

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH  
of birth of deceased is shown on 2411 N. Charles St., Baltimore *BDA*

05296

357

## CERTIFICATE OF DEATH

Reg. Dist. No.

FILM NO. 104 MAY 16 1946

## 1. PLACE OF DEATH:

County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rena Elizabeth Sturgis

4. Sex 5. Color or race 6. (d) Single, married, widowed, or divorced

Female White Widowed

B. (b) Name of husband or wife William E Sturgis

7. Birth date of deceased (mo., day, yr.) December 22 1873

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

72 4 15 hrs. min.

9. Birthplace Powellville Wicomico Maryland

(Town, county, and state)

10. Usual occupation House Wife

## 11. Industry or business

FATHER 12. Name James Cooper

13. Birthplace Powellville

MOTHER 14. Maiden name Elizabeth Bradford

15. Birthplace Powellville

16. Informant Roy C Sturgis

Address Delmar Md

17. Burial Date thereof May 8 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Whatcoat

Location Snow Hill Maryland

18. Funeral director Hearne &amp; Dennis

Address Snow Hill Maryland

19. (Date rec'd by registrar) 5/8/46 L. Day Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3. (b) Social Security Number

216096104

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/5/46 19 to 5/6/46 19

and that I last saw her alive on 5/5/46 19

19

Immediate cause of death

Hyper tension Cardiac-  
Vascular renal disease

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

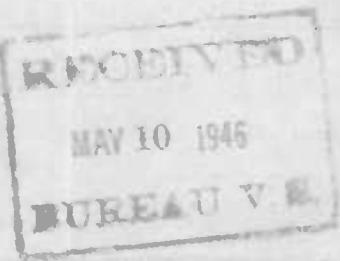
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Ober

M. D. or other

Address Snow Hill Date signed 5/6/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21201

## CERTIFICATE OF DEATH

05297

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.Hospital, institution, or street address where death occurred: How long in hospital or institution? 

## 3. (a) FULL NAME

Charles Mitchell Townsend

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White MARRIED

6. (b) Name of husband or wife

Hayel Townsend

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

54

years

Sept. 15 1882

8. AGE: Years

Months

Days

If less than one day

63

7

17

hrs.

min.

9. Birthplace

Berlin  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming

FATHER

12. Name Arthur Townsend

MOTHER

13. Birthplace Md.14. Maiden name Henrietta Williams15. Birthplace Md.16. Informant Hayel TownsendAddress Berlin, Md.

17. Burial

(Burial, cremation, or removal Which?)

Date thereof 5-4-46  
(month) (day) (year)Cemetery or crematory BuckinghamLocation Berlin, Md.18. Funeral director M. Pashay StationAddress Selbyville Del.19. Date rec'd by registrar May 2 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin (If outside city or town limits, write RURAL and give nearest town)Street No. RFD (If rural, give LOCATION)2.(a) If veteran, name war: 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1937 to May 2 1946and that I last saw her alive on May 2nd 1946

Immediate cause of death

Cerebral hemorrhage DURATION 3 hrsDue to Hypertension

10 yrs

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury .....

Injured at work? .....

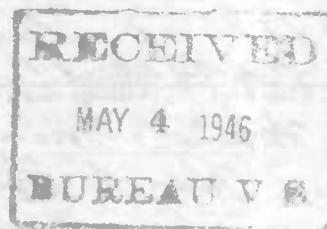
23. SIGNATURE L. L. Scioell M.D.

M. D. or other .....

Address Berlin, Md. Date signed 5/3/46

STAMP NO. 3750000000000000000000

OPTIONAL STATIONERY



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-B

05298

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I  
9-45-15

VS A15

## 1. PLACE OF DEATH:

County: Worcester

City or town: Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Julia Olive Rue Truett

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife: Francis Columbus Truett

7. Birth date of deceased (mo. day, yr.): March 15, 1857

8. AGE: Years: 89 Months: 1 Days: 27 If less than one day: hrs: min:

9. Birthplace: Pungataque Accomac Co., Va. (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: William Rue II

12. Name: William Rue II

13. Birthplace: Virginia

14. Maiden name: Julia Mason

15. Birthplace: Virginia

16. Informant: Mrs. Vaughan Rue Truett.

Address: Ellicott City, Md.

17. Burial Date thereof: 5/4/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Episcopalian Cemetery

Location: Berlin, Md.

18. Funeral director: Anna R. Burbage

Address: Berlin, Md.

19. 5-14 Date rec'd by registrar: 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Worcester

City or town: Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 45 to May 1946

and that I last saw h. alive on

Immediate cause of death:

Ch. nephritis

Due to:

Due to:

Other conditions:

Ch. myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE:

Chas. R. Law M. D. or other

Address: Berlin, Md. Date signed: 5-13-46

RECEIVED

MAY 16 1946

BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

05299

## CERTIFICATE OF DEATH

351

Reg. Dist. No.

1. PLACE OF DEATH:  
County..... *Worcester*

City or town..... *Middlesex*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *60 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME  
*Elayton P. West*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Fatherine B. West*

7. Birth date of deceased (mo., day, yr.) *Jan 24 - 1886*

6. (c) If alive, give age *60* years

7. Birth date of deceased (mo., day, yr.) *Jan 24 - 1886*

8. AGE: Years *60* Months *3* Days *18* If less than one day

hrs. *0* min. *0*

9. Birthplace *Middlesex, Worcester, Md.*

(Town, county, and state) *Farmer*

10. Usual occupation.....

11. Industry or business.....

12. Name..... *A. W. West*

13. Birthplace *Maryland*

14. Maiden name..... *Thamie B. Calhoun*

15. Birthplace *Maryland*

16. Informant..... *My Fatherine B. West*

Address *Middlesex, Md.*

17. Burial..... *Buried*

Date thereof..... *May 1946*

(Burial, cremation, or removal, which?) *Baptist Cemetery*

(month) (day) (year) *(month) (day) (year)*

Cemetery or crematory.....

Location..... *Middlesex, Md.*

18. Funeral director..... *Kearne, Dennis*

Address..... *Snow Hill, Md.*

19. Date rec'd by registrar..... *5/14/46*

(Date rec'd by registrar) *1946*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Worcester*

City or town..... *Middlesex*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION) *70*

2.(a) If veteran, name war.....

3. (b) Social Security Number *None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 12* 19 *46* at *8 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jamaica* 1945 to *May 12* 1946

and that I last saw h. m. alive on *May 12* 1946

Immediate cause of death..... *Multiple Sclerosis*

DURATION *7 yrs*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

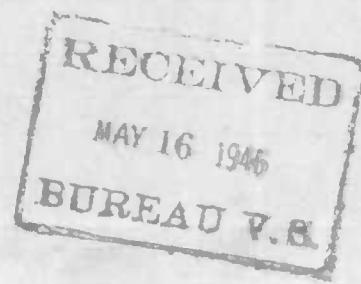
Means of injury..... Injured at work?

23. SIGNATURE *Paul Owen M.D.*

M. D. or other

Address..... *Snow Hill* Date signed *5/13/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 177

05300

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County.....

City or town.....

Worcester  
Pocomoke Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 68 years.

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

Clarence Major Winslow

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife..... Tileen Winslow

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

60 years

October 1 1878

8. AGE:

Years Months Days If less than one day  
67 7 10 hrs. min.

9. Birthplace

Pocomoke Worcester Md.

(Town, county, and state)

10. Usual occupation

Day labor

11. Industry or business

Paper School Jntg

FATHER

12. Name

Leth Winslow

MOTHER

13. Birthplace

Virginia

14. Maiden name

Addie Douglas

15. Birthplace

Virginia

16. Informant

Tileen Winslow

Address

Pocomoke Md.

17. Burial

Date thereof May 15, 1944

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Halls Hill

Location

Rural Pocomoke Md.

18. Funeral director

Henry Watson

Address

Pocomoke Md.

19. Date rec'd by registrar

May 14, 1946

Anne E. White

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Sixth street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

212-16-1954

## MEDICAL CERTIFICATION

20. DATE OF DEATH

5/10/1946 at 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/6 1946 to 5/9 1946

and that I last saw him alive on 19.

Immediate cause of death.....

Food poisoning 2 days

Due to meat sandwiches at a restaurant

Due to

Chronic bronchitis 2 yrs.  
a large amount of alcohol

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

7

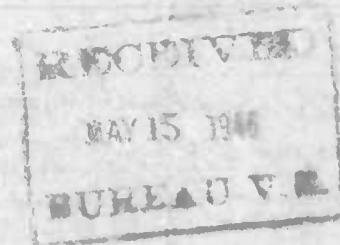
Injured at work?

23. SIGNATURE

P. H. Watson M. D. or other

Address.....

Pocomoke City Md. Date signed 5/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

05301

1. PLACE OF DEATH:  
County... Worcester  
City or town... Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Baby Wise4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced 

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 10 - 1946 8. (c) If alive, give age ..... years8. AGE: Years - Months - Days - If less than one day hrs. 10 min.9. Birthplace Maryland, Snow Hill  
(Town, county, and state)

10. Usual occupation.

## 11. Industry or business

12. Name Farmer 13. Birthplace Maryland14. Maiden name Gladysce Wise 15. Birthplace Maryland16. Informant Jack WiseAddress Snow Hill, Md17. Burial Date thereof May 10<sup>th</sup> 46  
(Burial, cremation, or removal. Which?) at homeCemetery or crematory at home Location Pocomoke Road, near Snow Hill18. Funeral director He and Son  
Address Snow Hill, Md.19. Date rec'd by registrar 5/10/46 LeRoy Smith  
Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Worcester  
City or town Snow Hill over River Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Washington St East If rural, Horace Moore Tenant house

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 10 19 46 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 19 46 to May 10 19 46and that I last saw him alive on May 10 19 46

Immediate cause of death

Premature - 5 mos Baby  
(Breaking of water)

DURATION

10 min

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other.....

Address..... Date signed 5-10-46

